STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101018	A. BUILDING: _____ B. WING _____	C 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAWN HEALTH & REHABILITATION CENTER	300 SHELBY STATION DRIVE LOUISVILLE, KY 40245

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	INITIAL COMMENTS A Complaint Survey was initiated on 09/03/15 and concluded on 09/04/15 to investigate complaint KY23794. The Division of Health Care substantiated the allegation with deficiencies cited.	N 000		
N 144	902 KAR 20:300-6(7)(b)2.a. Section 6. Quality of Life (7) Environment. (b) Infection control and communicable diseases. 2. The facility shall establish an infection control program which: a. Investigates, controls and prevents infections in the facility; This requirement is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure a resident with a suspected communicable disease had isolation precautions in place until the disease test results were determined and after positive results were obtained staff and visitors used the appropriate personal protective equipment. In addition, a resident with a known communicable disease and in contact isolation was observed to have a visitor not wearing the appropriate personal protective equipment while in the residents room for two (2) of five (5) sampled residents. (Resident's #1 and #5) The findings include: Review of the facility's policy regarding Initiating	N 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101018	A. BUILDING: _____ B. WING _____	C 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAWN HEALTH & REHABILITATION CENTER	300 SHELBY STATION DRIVE LOUISVILLE, KY 40245

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 144	Continued From page 1 Transmission Based Precautions, not dated, revealed Transmission-Based Precautions would be initiated when there was a reason to believe that a resident had a communicable infectious disease. Transmission-Based Precautions may include Contact Precautions, Droplet Precautions, or Airborne Precautions. Review of the facility's policy regarding Isolation for Transmission-Based Precautions, not dated, revealed in addition to Standard Precautions, the facility would implement Contact Precautions for residents known or suspected to be infected or colonized with micro-organisms that could be transmitted by direct contact with the resident or indirect contact with the environmental surfaces or resident-care items. Examples of infections requiring Contact Precautions included Diarrhea associated with Clostridium Difficile. In addition, Contact Precautions, would be implemented for wound infections colonized with multi-drug resistant organisms, such as Methicillin-resistant Staphylococcus Aureus (an infection caused by a strain of bacteria which has become resistant to the antibiotics commonly used to treat ordinary staph infections). While caring for residents in contact precautions, gloves would be worn upon entering the resident's room and gowns would be worn for all interactions that may involve contact with the resident or potentially contaminated items in the resident's environment. The facility would also ensure the residents care plan indicated the type of precautions implemented for the resident. 1. Interview with Resident #1' family member, on 09/03/15 at 9:17 AM, revealed that during the resident's stay at the facility Resident #1 experienced diarrhea and the physician ordered	N 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101018	A. BUILDING: _____ B. WING _____	C 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAWN HEALTH & REHABILITATION CENTER	300 SHELBY STATION DRIVE LOUISVILLE, KY 40245

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 144	Continued From page 2 the stool to be tested for Clostridium Difficile (C-diff.). The family member stated the test was ordered on 08/17/15; however, the facility did not obtain the stool for testing until he/she and the physician inquired about the results. The family member had assumed the test had already been completed and the facility had failed to report the results; not that the test had never been completed. He/she stated once the stool was collected, the results were positive for C- diff. The family member stated from the time of the ordered stool test until confirmation of C-diff; Resident #1 was not placed in isolation precautions and his/her grandchildren visited Resident #1. He/She had concerns for the health of the grandchildren. The family member stated even after the facility placed Resident #1 in isolation precautions, staff did not adhere to wearing the appropriate personal protective equipment when caring for the resident. Review of Resident #1's closed clinical record revealed the facility admitted the resident on 07/03/15 with diagnoses of Urinary Tract Infection, Diabetes, and Congestive Heart Failure. The facility discharged the resident on 07/30/15. Review of Resident #1's Annual Minimum Data Set (MDS) assessment, completed on 07/10/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of fourteen (14) meaning the resident was interviewable. Review of the Physician Orders, dated 07/13/15, revealed the physician ordered a stool study with cultures to determine if the resident had Clostridium Difficile due to the resident	N 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101018	A. BUILDING: _____ B. WING _____	C 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAWN HEALTH & REHABILITATION CENTER	300 SHELBY STATION DRIVE LOUISVILLE, KY 40245

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 144	Continued From page 3	N 144		

experiencing diarreah. Review of the laboratory results, dated 07/24/15, revealed Resident #1 tested positive for Clostridium Difficile eleven days after the order was obtained.

Interview with the Unit Manager (UM), on 09/03/15 at 3:30 PM, revealed residents would be placed in isolation if diagnosed with a contagious disease. The Unit Manager #1 stated a sign would be placed on the door noting isolation precautions and the appropriate personal protective equipment would be placed outside the door for staff and visitors to use. The UM stated staff and visitors should adhere to the isolation precautions at all times to prevent the spread of infection.

Interview with the Director of Nursing (DON), on 09/04/15 at 2:58 PM, revealed she was responsible for the Infection Control Program in the facility. She stated she had received a complaint from Resident #1's family regarding not obtaining the ordered stool specimen timely to test for Clostridium Difficile. However, the family member had not said anything about not following infection control practices. She stated the facility would not put a resident into contact precautions for a case of suspected Clostridium Difficile (C-diff.), even though the facility policy stated resident's would be placed in precautions for a suspected case of C-diff. She stated they did not put Resident #1 in isolation with contact precautions, until after they received the positive test result, confirming the resident had C-diff. The DON stated nursing management was responsible for monitoring and ensuring infection prevention interventions were implemented. The DON did not provide evidence of infection prevention activities or the monitoring of staff for compliance with wearing the appropriate personal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101018	A. BUILDING: _____ B. WING _____	C 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAWN HEALTH & REHABILITATION CENTER	300 SHELBY STATION DRIVE LOUISVILLE, KY 40245

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 144	Continued From page 4 protective equipment. 2. Review of Resident #5's clinical record revealed the facility admitted the resident on 08/30/15 with diagnoses of Sepsis, Cancer of the Vulva, Methicillin-resistant Staphylococcus Aureus (an infection caused by a strain of bacteria which has become resistant to the antibiotics commonly used to treat ordinary staph infections) of the right lower extremity and elbow. Review of Resident #5's Social Services note, completed on 09/04/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of fifteen (15) meaning the resident was interviewable. Observation, on 09/03/15 at 2:52 PM, of Resident #5's room, revealed an isolation sign for Contact Precautions was on the wall outside the room. Continued observation revealed a visitor was seated on a couch and was not wearing the appropriate gown and gloves required for contact precautions. Interview with Resident #5, on 09/04/15 at12:30 PM, revealed not all staff or the visitors adhered to the isolation precautions or wore the appropriate personal protective equipment (PPE), while in his/her room. Resident #5 stated the visitor that came on 09/03/15, believed they could not be infected with MRSA as long as they did not touch him/her. The resident stated he/she was not aware that MRSA could be contracted by others after touching surfaces he/she had touched and had not been cleaned. Interview with Certified Nursing Assistant (CNA #1, on 09/03/15, at 3:13 PM, revealed he was	N 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101018	A. BUILDING: _____ B. WING _____	C 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAWN HEALTH & REHABILITATION CENTER	300 SHELBY STATION DRIVE LOUISVILLE, KY 40245

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 144	Continued From page 5	N 144		

assigned to provide care to Resident #5. CNA #1 stated the resident was in isolation for MRSA of the wound and all staff and visitors were to put on the appropriate PPE prior to entering the room. He stated he did not know a visitor was in Resident #5's room without the appropriate PPE. He stated wearing the PPE prevented the spread of the infection.

Interview with Licensed Practical Nurse #1, on 09/03/15 at 2:57 PM, revealed Resident #5 had MRSA of the wound and was on Contact Precautions to prevent the spread of the disease. She stated all staff and visitors should wear the appropriate personal protective equipment (PPE) prior to entering the room. However, was not aware the resident had a visitor in the room who was not wearing the appropriate PPE. She stated it was important for everyone to follow Contact isolation precautions to prevent the spread of infections and it was the responsibility of staff to monitor for compliance.

Interview with the Director of Nursing (DON), on 09/04/15 at 2:58 PM, revealed staff and visitors should follow the Contact Precaution and isolation requirements to prevent the spread of infection for Resident #5. However, she was not aware Resident #5 had a visitor wo was not wearing the appropriate PPE. She stated it was the responsibility of staff to ensure the Contact Isolation precautions were followed.

Interview with the Interim Administrator, on 09/04/15 at 4:25 PM, revealed she was not aware staff and visitors were not adhering to Contact Precaution requirements to prevent the spread of infections. She stated obviously the facility needed re-education and training on infection prevention. She stated it was the responsibility of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101018	A. BUILDING: _____ B. WING _____	C 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAWN HEALTH & REHABILITATION CENTER	300 SHELBY STATION DRIVE LOUISVILLE, KY 40245

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 144	Continued From page 6 the facility management to ensure infection prevention policies were followed.	N 144		
N 185	902 KAR 20:300-7(2)(e) Section 7. Resident Assessment (2) Comprehensive assessments. (e) Use. The results of the assessment are used to develop, review, and revise the resident's comprehensive plan of care, under subsection (4) of this section. This requirement is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to develop a care plan with interventions to care for a resident with Clostridium Difficile (a bacterium that causes diarrhea and more serious intestinal conditions) for one (1) of five (5) sampled residents. (Resident #1) The findings include: The facility did not provide a policy regarding the development of resident's care plans. Review of the Resident Assessment Instrument (RAI), Minimum Data Set (MDS), Chapter 4, page 4-8, revealed the facility was responsible for assessing and addressing all care issues that are relevant to the individual residents, regardless of whether or not they are covered by the RAI, including monitoring each resident's condition and responding with appropriate interventions. Page 4-12 revealed the overall care plan should be oriented towards: preventing avoidable declines; managing risk factors; addressing resident's	N 185		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101018	A. BUILDING: _____ B. WING _____	C 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAWN HEALTH & REHABILITATION CENTER	300 SHELBY STATION DRIVE LOUISVILLE, KY 40245

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 185	Continued From page 7	N 185		

strength; evaluating treatments; and, addressing additional care planning areas that are relevant to meeting the resident's needs.

Review of the facility's policy regarding Initiating Transmission Based Precautions, not dated, revealed Transmission-Based Precautions would be initiated when there was a reason to believe that a resident had a communicable infectious disease. Transmission-Based Precautions may include Contact Precautions, Droplet Precautions, or Airborne Precautions.

Review of the facility's policy regarding Isolation for Transmission-Based Precautions, undated, revealed in addition to Standard Precautions, the facility would implement Contact Precautions for residents known or suspected to be infected or colonedzed with micro-organisms that could be transmitted by direct contact with the resident or indirect contact with the environmental surfaces or resident-care items. Examples of infections requiring Contact Precautions included Diarrhea associated with Clostridium Difficile. The facility would also ensure that the residents care plan indicated the type of precautions implemented for the resident.

Review of Resident #1's closed clinical record revealed the facility admitted the resident on 07/03/15 with diagnoses of Urinary Tract Infection, Diabetes, and Congestive Heart Failure. The facility discharged Resident #1 on 07/30/15.

Review of Resident #1's Annual Minimum Data Set (MDS) assessment, completed on 07/10/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of fourteen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101018	A. BUILDING: _____ B. WING _____	C 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAWN HEALTH & REHABILITATION CENTER	300 SHELBY STATION DRIVE LOUISVILLE, KY 40245

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 185	Continued From page 8 (14) meaning the resident was interviewable. Review of Physician Orders, dated 07/13/15, revealed Resident #1 had diarrhea and the physician ordered a stool study with cultures to determine if the resident had Clostridium Difficile. Review of Laboratory results, dated 07/24/15, revealed Resident #1 tested positive for Clostridium Difficile. Review of the Comprehensive Care Plan for Resident #1, revealed a plan of care was not developed at the time the physician suspected or after the facility received confirmation, Resident #1 had the infectious disease, Clostridium Difficile. Interview with Unit Manager #1, on 09/04/15 at 9:10 AM, revealed after a nurse received a physician's order she should update the resident's care plan with the appropriate interventions related to the order. The Unit Manager stated she did not update the care plan at that time she received the order to collect Resident #1's stool for the contagious disease of Clostridium Difficile. She stated a care plan related to infection control of Clostridium Difficile should have been developed in order for staff to know how to care for the resident. Interview with the Director of Nursing, on 09/04/15 at 2:58 PM, revealed she received a complaint from Resident #1's family regarding not obtaining the ordered stool specimen timely and not about staff not using the appropriate personal protective equipement. She stated she did not know, until discussion with surveyor, that nursing had not developed a plan of care related to the order for stool collection or after the confirmed	N 185		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101018	A. BUILDING: _____ B. WING _____	C 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAWN HEALTH & REHABILITATION CENTER	300 SHELBY STATION DRIVE LOUISVILLE, KY 40245

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 185	Continued From page 9 diagnosis of Clostridium Difficile. She stated a care plan should have been developed related to infection control practices in order for staff to know how to care for the resident. Interview with Interim Administrator, on 09/04/15 at 4:25 PM, revealed she had been informed of Resident #1's family's complaint regarding the lack of timeliness in collecting the stool specimen. However, she had not been told that Resident #1 did not have a care plan developed after the order for stool collection or the positive test results were received. She stated obviously the facility still had education and training to complete related to the complaint. She stated nursing should have developed a care plan for Resident #1 in order to provide the necessary care and services and prevent the spread of the infection.	N 185		
N 194	902 KAR 20:300-7(4)(c)2. Section 7. Resident Assessment (4) Comprehensive care plans. (c) The services provided or arranged by the facility shall: 2. Be provided by qualified persons in accordance with each resident's written plan of care. This requirement is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to follow resident care plans related to specimen collection for occult blood and infection control practices for two (2) of five (5) sampled residents. (Resident's #3 and #5).	N 194		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101018	A. BUILDING: _____ B. WING _____	C 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAWN HEALTH & REHABILITATION CENTER	300 SHELBY STATION DRIVE LOUISVILLE, KY 40245

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 194	Continued From page 10 The findings include: The facility did not provide a policy regarding following the resident's care plan nor the collection of specimens. Review of the Resident Assessment Instrument (RAI), Minimum Data Set (MDS), Chapter 4, page 4-10 revealed key task of the care planning process is monitoring the individual's progress towards goals and modifying approaches an needed. The key tasks in the care delivery process included: identify the individual's response to interventions and treatments; identify factors effecting progress towards achieving goals; define or refine when to stop or modifiy interventions, review effectiveness and adverse consequences related to treatments; adjust interventions as needed; and, identify when care objectives have been achieved sufficiently to allow for discharge, transfer, or change in level of care. Review of the facility's policy regarding Isolation for Transmission-Based Precautions, not dated, revealed the facility would also ensure the residents care plan indicated the type of precautions implemented for the resident. 1. Review of Resident #3's clinical record revealed the facility admitted the resident on 08/11/15 with diagnoses of Perpherial Vascular Disease, Kidney Failure, and Atrial Fibrillation. Review of Resident #3's Annual Minimum Data Set (MDS) assessment, completed on 0/8/18/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of thirteen (13) meaning the resident was interviewable.	N 194		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101018	A. BUILDING: _____ B. WING _____	C 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAWN HEALTH & REHABILITATION CENTER	300 SHELBY STATION DRIVE LOUISVILLE, KY 40245

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 194	Continued From page 11 Review of the Comprehensive Care Plan for Resident #3 revealed a plan was developed on 08/24/15 with updated goals and a target date for 08/24/15. The problem stated the resident was at risk for complications related to anticoagulation therapy. The goal stated the resident would not have active bleeding. The approaches directed the staff to observe for signs of active bleeding i.e., nose bleeds, bleeding gums, blood in urine or stool. Observation, on 09/03/15 at 1:08 PM, revealed Resident #3 was in bed watching television. The resident appeared clean, well groomed with call light and fluids in reach. Interview with resident on, 09/04/15 at 11:25 PM, revealed a specimen for occult blood was collected on 09/03/15 and the resident did not know when the specimen was ordered to be collected. Review of Physician Orders, dated 08/17/15, revealed the physician ordered Resident #3's stool to be tested two (2) times for occult blood. Interview, on 09/03/15 at 1:05 PM, with Licensed Practical Nurse #2 revealed a nursing intervention for Resident #3 required nursing to observe for signs and symptoms of bleeding in Resident #3's stool. She stated completing the ordered test would be one way to observe for bleeding in the stool. She stated as of, 09/03/15, the test had not been completed and did not know the reason for the delay. Interview with Unit Manager #1, on 09/03/15 at 3:30 PM, revealed his responsiblity was to ensure nursing interventions were followed. He stated Resident #3 had a care plan intervention to monitor the stool for blood. He stated he was not	N 194		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101018	A. BUILDING: _____ B. WING _____	C 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAWN HEALTH & REHABILITATION CENTER	300 SHELBY STATION DRIVE LOUISVILLE, KY 40245

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 194	Continued From page 12	N 194		

aware the physician ordered test, to monitor for blood in Resident #3's stool, had not been completed timely. He stated he reviewed the copies of the physician orders at the beginning of each shift to ensure they had been faxed and transcribed to the appropriate location, but did not ensure nursing had implemented the intervention. He stated the resident could have a bad outcome if nursing did not implement care plan interventions.

Interview with the Assistant Director of Nursing, on 09/03/15 at 1:15 PM, revealed one of Resident #3's care plan interventions required nursing to monitor for signs and symptoms of bleeding in the stool. She stated the collection and testing of the stool specimen should have been done as soon as possible after receiving the order on 08/17/15. She stated she was not aware seventeen days had past, and the ordered nursing intervention had not been implemented. She stated resident care plan interventions should be followed and was not sure where the breakdown in the process occurred.

Interview with the Director of Nursing, on 09/04/15 at 2:58 PM, revealed she was not aware Resident #3's care plan intervention for monitoring stool for blood had not been implemented. She stated nursing should be monitoring to make sure the intervention had been implemented and there was a breakdown in the process, but was not sure how it happened. She stated implementing care plan interventions was important for the care of the resident. She stated if care plan interventions were not implemented a negative outcome for the resident could occur.

2. Review of Resident #5's clinical record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101018	A. BUILDING: _____ B. WING _____	C 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAWN HEALTH & REHABILITATION CENTER	300 SHELBY STATION DRIVE LOUISVILLE, KY 40245

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 194	Continued From page 13	N 194		

revealed the facility admitted the resident on 08/30/15 with diagnoses of Sepsis, Cancer of the Vulva, Methicillin-resistant Staphylococcus Aureus (an infection caused by a strain of bacteria which has become resistant to the antibiotics commonly used to treat ordinary staph infections) of the right lower extremity and elbow.

Review of Resident #5's Social Services note, completed on 09/04/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of fifteen (15) meaning the resident was interviewable.

Observation, on 09/03/15 at 2:52 PM, revealed an isolation sign for Contact Precautions was on the wall outside Resident #5's room. Continued observation of Resident #5's room revealed a visitor was seated on a couch and did not have on the appropriate gown and gloves needed for contact precautions.

Interview with Resident #5, on 09/04/15 at12:30 PM, revealed not all staff or the visitors adhered to the isolation precautions or wore the appropriate personal protective equipment (PPE), while in his/her room. Resident #5 stated the visitor that came on 09/03/15 believed they could not be infected with MRSA as long as they did not touch him/her. The resident stated he/she was not aware that MRSA could be contracted by others after touching surfaces he/she had touched and had not been cleaned.

Review of the Comprehensive Care Plan for Resident #5 revealed a plan was developed on 08/31/15 with updated goals and a target date for 09/04/15. The problem stated the resident had Methicillin-resistant Staphylococcus aureus

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101018	A. BUILDING: _____ B. WING _____	C 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAWN HEALTH & REHABILITATION CENTER	300 SHELBY STATION DRIVE LOUISVILLE, KY 40245

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 194	Continued From page 14	N 194		

(MRSA). The care plan did not have a goal stated. The approaches directed the staff to maintain Contact isolation for possible MRSA of right lower extremity and to provide treatment as ordered.

Interview with Certified Nursing Assistant (CNA) #1, on 09/03/15, at 3:13 PM, revealed he was assigned to provide care to Resident #5. CNA #1 stated the resident was in isolation for MRSA of the wound and all staff and visitors were to wear the appropriate PPE while in the room. He stated he did not know there was a visitor in Resident #5's room without the appropriate PPE. He stated wearing the PPE was part of the plan of care for the resident.

Interview with Lisenced Practical Nurse #1, on 09/03/15 at 2:57 PM, revealed Resident #5 had MRSA of the wound and was on Contact Precautions to prevent the spread of the disease. She stated all staff and visitors should wear the appropriate personal protective equipment (PPE) prior to entering the room. However, was not aware the resident had a visitor in the room not wearing the appropriate PPE. She stated the resident's plan of care for Contact isolation should be followed by all and it was the responsibility of staff to monitor for compliance.

Interview with the Director of Nursing (DON), on 09/04/15 at 2:58 PM, revealed staff and visitors should follow the Contact Precaution and isolation requirments to prevent the spread of infection for Resident #5. However, was not aware Resident #5 had a visitor not wearing the appropriate PPE. She stated it was the responsibility of staff to ensure the care plan interventions were followed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101018	A. BUILDING: _____ B. WING _____	C 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAWN HEALTH & REHABILITATION CENTER	300 SHELBY STATION DRIVE LOUISVILLE, KY 40245

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 199	Continued From page 15	N 199		
N 199	902 KAR 20:300-8 Section 8. Quality of Care Each resident shall receive the necessary nursing, medical and psychosocial services to attain and maintain the highest possible mental and physical functional status, as defined by the comprehensive assessment and plan of care. Each resident shall receive services and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This requirement is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure nursing staff followed physician orders related to specimen collection and testing for Clostridium Difficile and occult blood in the stool for two (2) of five (5) sampled residents. (Resident's #1 and #3) The findings include: The facility did not provide a policy or procedure related to following physician orders or specimen collection. 1. Review of Resident #1's closed clinical record revealed the facility admitted the resident on 07/03/15 with diagnoses of Urinary Tract Infection, Diabetes, and Congestive Heart Failure. The facility discharged the resident on	N 199		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101018	A. BUILDING: _____ B. WING _____	C 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAWN HEALTH & REHABILITATION CENTER	300 SHELBY STATION DRIVE LOUISVILLE, KY 40245

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 199	Continued From page 16 07/30/15. Review of Resident #1's Annual Minimum Data Set (MDS) assessment, completed on 07/10/15, revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of fourteen (14) meaning the resident was interviewable. Review of the Comprehensive Care Plan for Resident #3 revealed a plan was developed on 08/24/15 with updated goals and a target date for 08/24/15. The problem stated the resident was at risk for complications related to anticoagulation therapy. The goal stated the resident would not have active bleeding. The approaches directed the staff to observe for signs of active bleeding i.e., nose bleeds, bleeding gums, blood in urine or stool. Review of the Physician Orders, dated 07/13/15, revealed Resident #1 had diarrhea and the physician ordered a stool study with cultures to determine if the resident had Clostridium Difficile. Review of the Laboratory results, dated 07/24/15, revealed Resident #1 tested positive for Clostridium Difficile. On 09/04/15 at 9:10 AM, an Interview with Unit Manager (UM) #1 revealed after a nurse received a physician order it should be implemented as soon as possible. She stated she was not aware of the ten day delay in collecting the stool specimen until the family inquired about the test results. The Unit Manager stated she did not know where the breakdown in the facility's process to collect Resident #1's stool occurred; but believed nursing failed to communicate from shift to shift that the specimen had not been	N 199		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101018	A. BUILDING: _____ B. WING _____	C 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAWN HEALTH & REHABILITATION CENTER	300 SHELBY STATION DRIVE LOUISVILLE, KY 40245

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 199	Continued From page 17	N 199		

collected. She stated she reviewed physician orders daily to ensure they were faxed to the laboratory and pharmacy, but not to determine if they were completed.

Interview with the Director of Nursing (DON), on 09/04/15 at 2:58 PM, revealed she received a complaint from Resident #1's family regarding not obtaining the ordered stool specimen and test results timely. The DON stated nursing should implement physician orders as soon as possible after receiving the order. She stated she believed the nursing staff had a shift to shift communication problem; however, had not addressed this issue as of yet.

Interview with Interim Administrator, on 09/04/15 at 4:25 PM, revealed she had been informed of Resident #1's family's complaint regarding the lack of timeliness in collecting a stool specimen. The Interim Administrator stated the family's complaint was addressed and believed actions were put in place to prevent this type of issue from occurring again; however, was not aware this surveyor found a physician order, dated 08/17/15, for another resident that had not been implemented until surveyor intervention. She stated obviously the facility still had education and training to complete related to the following of physician orders. She stated nursing should follow and implement physician orders timely or residents could potentially experience a negative outcome.

2. Review of Resident #3's clinical record revealed the facility admitted the resident on 08/11/15 with diagnoses of Periphera Vascular Disease, Kidney Failure, and Atrial Fibrillation. Review of Resident #3's Annual Minimum Data Set (MDS) assessment, completed on 0/8/18/15,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101018	A. BUILDING: _____ B. WING _____	C 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAWN HEALTH & REHABILITATION CENTER	300 SHELBY STATION DRIVE LOUISVILLE, KY 40245

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 199	Continued From page 18	N 199		

revealed a Brief Interview for Mental Status (BIMS) exam was conducted and the facility assessed the resident with a score of thirteen (13) meaning the resident was interviewable.

Review of the Comprehensive Care Plan for Resident #3 revealed a plan was developed on 08/24/15 with updated goals and a target date for 08/24/15. The problem stated the resident was at risk for complications related to anticoagulation therapy. The goal stated the resident would not have active bleeding. The approaches directed the staff to observe for signs of active bleeding i.e., nose bleeds, bleeding gums, blood in urine or stool.

Observation, on 09/03/15 at 1:08 PM, revealed Resident #3 was in bed watching television. The resident appeared clean, well groomed with call light and fluids in reach. Interview with the resident on, 09/04/15 at 11:25 PM, revealed a specimen for occult blood was collected on 09/03/15 and the resident did not know when the specimen was ordered to be collected.

Review of Physician Orders, dated 08/17/15, revealed the physician ordered Resident #3's stool to be tested two (2) times for occult blood.

On 09/03/15 at 1:05 PM, an interview with Licensed Practical Nurse (LPN) #2 revealed a nursing intervention for Resident #3 required nursing to observe for signs and symptoms of bleeding in Resident #3's stool. LPN #2 stated completing the ordered test would be one way to observe for bleeding in the stool. She stated physician orders should be implemented as soon as possible after receiving. However, as of 09/03/15, the test had not been completed and did not know the reason for the delay.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101018	A. BUILDING: _____ B. WING _____	C 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAWN HEALTH & REHABILITATION CENTER	300 SHELBY STATION DRIVE LOUISVILLE, KY 40245

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 199	Continued From page 19 Interview with Unit Manager (UM) #1, on 09/03/15 at 1:05 PM, revealed his responsibility was to ensure nursing interventions were followed. UM #1 stated Resident #3 had a care plan intervention to monitor the stool for blood. UM #1 stated he was not aware the physician ordered test, to monitor for blood in Resident #3's stool, had not been completed timely. He stated he reviewed the copies of the physician orders at the beginning of each shift to ensure they had been faxed and transcribed to the appropriate location, but did not ensure nursing had implemented the intervention. He stated the resident could have a bad outcome if nursing did not follow physician orders. Interview with the Assistant Director of Nursing, on 09/03/15 at 1:15 PM, revealed the collection and testing of Resident #3's stool, should have been done as soon as possible after receiving the order on 08/17/15. She stated she was not aware seventeen days had past, and the ordered nursing intervention had not been implemented. She stated physician orders should be followed timely and was not sure where the breakdown in the process occurred. Interview with the Director of Nursing, on 09/04/15 at 2:58 PM, revealed she was not aware Resident #3's physician order to test stool for occult blood had not been implemented. She stated nursing should be implementing physician orders immediately after receiving them. She stated she was not sure where the breakdown in the process occurred, but believed the staff had a communication issue. She stated if physician orders were not implemented the resident could experience a bad outcome.	N 199		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101018	A. BUILDING: _____ B. WING _____	C 09/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAWN HEALTH & REHABILITATION CENTER	300 SHELBY STATION DRIVE LOUISVILLE, KY 40245

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 199	Continued From page 20 On 09/04/15 at 4:25 PM, an interview with Interim Administrator revealed she was not aware Resident #3's occult blood stool test, ordered on 08/17/15, had not been done. She stated nursing was responsible for ensuring physician orders were implemented as soon as possible. She stated obviously the staff needed re-training and education on the importance of following physician orders and their timely implementation.	N 199		